United States Department of State

Bureau of Human Resources
Office of Retirement
Room H-620, SA-1
Washington, D.C. 20522

FEDERAL EMPLOYEES HEALTH BENEFITS ENTITLEMENT IN ACCORDANCE WITH THE CIVIL SERVICE SPOUSE EQUITY ACT, 1984

STATEMENT OF UNDERSTANDING & ELECTION FORM

I understand that the **Office of Retirement (HR/RET), SA-1, Room H-620, Department of State, Washington, DC 20522-0108**, must be notified within 31 days of one or more of the following events, and that the occurrence of any one of the events will result in termination of my enrollment under the **Federal Employees Health Benefits (FEHB) Program**. I understand that once the enrollment is terminated, I may not reenroll.

(1) The court order ceases to provide entitlement to pension or survivor annuity benefit under the Foreign Service Retirement System.
(2) I remarry before age 55.
(3) The employee, on whose service the benefits are based, dies and no survivor annuity is payable.
(4) The separated employee, on whose service the benefits are based, dies before the requirements for a deferred annuity have been met.
(5) The employee, on whose service the benefits are based, leaves Federal service before establishing title to an immediate or deferred annuity.
(6) A refund of retirement monies is paid to the separated employee on whose service health benefits are based.
(7) I fail to pay premiums within the established timeframe. (Termination is retroactive to the end of the last pay period for which payment has been timely received.)
(8) My death.

I understand that if I elect to cancel my enrollment, I may not reenroll **AND** I will not be entitled to the temporary extension of coverage for conversion to an individual contract for health benefits. I also understand that I may defer enrollment in the FEHB Program. (Reasons for deferral may be that you are already covered under your own FEHB plan or you have other health insurance coverage at this time.)

PLEASE CHECK ONE:

☐ I elect to enroll in the Federal Employees Health Benefits Plan. My completed SF-2809 is attached.

☐ I elect not to enroll in the Federal Employees Health Benefits Plan.

☐ I elect to defer enrollment in the Federal Employees Health Benefits Plan.

If deferred, reason for deferment: _____

_____

I have not been married since my divorce on _____. If remarried, give date: _____

SIGNATURE: _____ ***SOCIAL SECURITY NUMBER:*** _____

PRINTED NAME: _____ ***DATE***: _____

NAME OF FORMER SPOUSE: _____

WARNING: Any intentional false statement on this form of willful misrepresentation relative thereto, is a violation of law punishable by a fine of not more than $10,000, or imprisonment of not more than 5 years, or both (18 US Code 1001).